FACILITY NAME:
Facility ID #
Instructions for Form Completion on Page 4
****** *PLEASE WRITE LEGIBLY!* ******

See Trauma Registry Inclusion Criteria Page 4

DEMOGRAPHIC

Record # **(Assigned by Hospital)**

Record # **(Assigned by State)**

Abstract Date
Mo Day Year

Abstract completed by:

Race
White
Black
Hispanic
American Indian
Asian
NativeHawaiian/Pacific Islander
Other

Social Security #
(Last 4 digits only)
_____

Sex
Male
Female

Date of Birth
Mo ____ Day _____ Year _____

PREHOSPITAL

How Arrived to Emergency Department
Ambulance
Helicopter
Police
Private Vehicle
Other
_____

Name of EMS Service

Prehospital trip sheet on chart?
Y / N

Injury Date
___/___/___

Injury Time
____:____

Cause of Injury - Give as complete a description as possible for etiology coding purposes.

Place of Injury Occurrence
Home
Farm
Mine/Quarry
Industrial Place
Place for Sports/Recreation
Street/Highway
Public Building
Residential Institution
Other Specified Place
Unspecified

City Where Injury Occurred

Work Related?
Y / N

Occupation_____

Was patient extricated?
Y / N _____ minutes

Type of Injury
Blunt
Penetrating
Burn
TBSA % _____
Anoxic

Intent
Intentional, Self-Inflicted
Intentional, Assault
Accidental

Was patient intubated?
Y / N Time: _____:_____
OF ATTEMPTS _____
Method:
Nasal ETT
Oral ETT
King Tube
Cricothyrotomy
Combitube
Other

Protective Devices
None
Airbag
___front
___side
___curtain
Seatbelt
Helmet
Childseat
Other

Blunt Injury Cause
Motor Vehicle Crash
- driver
- passenger
Fall
Assault
Motorcycle/ATV/Snowmobile
Pedestrian
Bicycle / Moped
Horse Related
Other

Penetrating Injury Cause
Knife
Handgun
Shotgun
Rifle
Other

Time
Dispatched: _____:_____
En Route: _____:_____
Arrive Scene: _____:_____
Leave Scene: _____:_____
Arrive Hospital: _____:_____
Type EMS IV Fluid _____
Amount EMS IV Fluid _____

Scene Vital Signs
Time: _____:____
SpO2 _____
Pulse Rate _____
Respiratory Rate _____
Systolic Blood Pressure _____
Temperature _____

GCS Eye Opening
1 None
2 To Pain
3 To Voice
4 Spontaneous

GCS Verbal Response
1 None
2 Incomprehensible Sounds
3 Inappropriate Words
4 Confused
5 Oriented

GCS Motor Response
1 None
2 Extension
3 Flexion
4 Withdraws
5 Localizes
6 Obeys

GCS Total
_____

Memo/Pertinent Details

Triage Criteria Used for Trauma Team Activation from Field
Physiologic
Anatomy of Injury
Mechanism of Injury
Age
Co-morbid Condition
Gut Feel

EMERGENCY DEPARTMENT

Physician Name/Specialty | ***Time Called*** | ***Time Arrived***

_____ ___:___ ___:___

_____ ___:___ ___:___

_____ ___:___ ___:___

_____ ___:___ ___:___

_____ ___:___ ___:___

Was patient previously admitted to hospital for this injury?

Y / N

Trauma Team Activated?

Y / N

Time: _____:_____

Patient Arrival

Date: ___/___/___

Time: ____:_____

CT Scan

Time: ____:____

Location

Head
Neck
Thorax
Abdomen
Pelvis
Other _____

Were paralytic agents utilized?

Y / N

Was patient intubated? ***Time***

Y / N _____:_____

 # OF ATTEMPTS _____

Method

Nasal ETT Oral ETT Combitube
Cricothyrotomy King Tube Other

Trauma Flowsheet Used?

Y / N

Vital Signs

Time: ____:____
Initial ED Temperature _____

Route: _____

SpO2 _____

Pulse Rate _____

Resp Rate _____

Systolic BP _____
Dismissal Temp _____

Blood Products Received

Number

PRBC _____

FFP _____

Blood Alcohol Content

_____

Not Done

None Detected

Drug Screen

Not Done
Cannabis
Cocaine
Narcotics
Benzodiazepine

None Detected
Barbiturates
PCP
Amphetamines
Other _____

If admitted; Admitting MD Specialty

General Surgery Orthopedics

Family Practice Internal Medicine

Other _____

Date Left ED: _____/_____/_____

Time Left ED _____:_____

Type of ED IV Fluid _____

Amount of ED IV Fluid _____

GCS Eye Opening
1 None
2 To Pain
3 To Voice
4 Spontaneous

GCS Verbal Response
1 None
2 Incomprehensible Sounds
3 Inappropriate Words
4 Confused
5 Oriented

Post ED Destination **Circle One**

Admitted to:: OR ICU Floor

Home

Morgue/Time of Death ____:_____

***Transferred to:** Acute Care Facility Burn Center
Jail/Prison Skilled Nursing Facility
Other

GCS Motor Response
1 None
2 Extension
3 Flexion
4. Withdraws
5. Localizes
6. Obeys

GCS Total

_____

Facility Name and How Transferred:

_____

Circle one:

ground ambulance helicopter

air-fixed wing private vehicle

other _____

Memo/Pertinent Details

OUTCOME

If admitted to this Facility:
Date of Discharge: _____/_____/_____

***Time of Discharge*:** _____:_____

Pre-Existing Diseases / Conditions:

_____
_____
_____
_____
_____

Payor Source(s) (select up to two)

Automotive	Champus	Commercial	HMO	Indian Health Services	Medicare
Medicaid	Self Pay	Workmans' Comp..	No Charge/Write Off	Blue Cross/Blue Shield	

PROCEDURES / TIME PERFORMED

EMS PROCEDURES

Airway **Time:**

Bag Valve Mask ___:___
Combitube ____:____
ETT ____:____
Cric ____:____
King tube ____:____
Other ____:____

Cervical Spine **Time**

Cervical Collar/Backboard ___:___

Breathing **Time**

Pulse Oximetry ____:_____
Oxygen ____:_____
Oxygen Route _____

Circulation **Time**

Cardiac monitor ____:___
IV, peripheral ____:___
IV, intraosseous ____:___
CPR ____:___

Expose

Warming Measures ____:___
Splinting ____:___
Wound Care ____:___

ED Procedures

Airway **Time**

Bag Valve Mask Ventilation ____:____
Combitube ____:____
Endotracheal Intubation ____:____
Tracheostomy or Cricothyrotomy ____:____
King Tube ___:_____
Other ____:____

Cervical Spine **Time**

Cervical Collar/ Backboard ____:____

Breathing **Time**

Pulse Oximetry ____:____
Oxygen ____:____
Oxygen Route _____
Arterial Blood Gases ____:____
Thoracostomy, Needle ____:____
Chest Tube Insertion ____:____

Circulation

ECG Monitor ____:____
IV, Peripheral ____:____
IV, Central Line ____:____
IV, Intraosseous ____:____
Baseline Lab ____:____
CPR ____:____
Suture Laceration ____:____

Time

Expose (Temperature Control)

Warming Measures ____:____

Secondary Survey

X-ray (Circle applicable ones) ____:____
Chest, C-Spine, Pelvis,
Other _____
Splinting ____:____
Naso- or Oro-gastric Tube ____:____
Foley Catheter ____:____
Wound Care ____:____
Other: _____

ANATOMICAL DIAGNOSES	*Loss of Consciousness?* Y / N	*Duration of Coma:* _____ Hours / Minutes

Complete Description of Diagnoses, Potential/Actual Injuries

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completion Instructions for Trauma Registry Paper Date Abstract Form:

a. **Circle a response –** do not leave any items blank**.**
b. If you have no information for this item, write **'unk'** for unknown**.**
c. If the item does not apply to this patient, write **'NA'** for not applicable.
d. For **Memo/Pertinent Detail fields –** complete with any information you feel would be needed to document care given.

Trauma Registry Inclusion Criteria

April 2008

Column I

PRIMARY

criteria for inclusion

MUST have Discharge diagnosis of injuries (ICD-9 codes between 800.0 - 959.9)

These injuries are also included;

All patients with burns and a trauma mechanism of injury or meeting severity criteria for referral by the American Burn Association or;

994.0 - lightning

***994.8* – electrical current**

All patients with anoxic brain injuries due to a trauma mechanism of injury:

994.1 - drowning;

994.7 - asphyxiation and strangulation: suffocated by - cave in, constriction, pressure, strangulation, mechanical, bed clothes, plastic bag

➔AND
Must have one or more from
Column II

Column II

All patients that initiated FULL *or* PARTIAL Trauma Team Activation at your facility

All patients hospitalized at your facility for 48 hours or more

All patients with admission to an Intensive Care Unit at your facility

All patients who die in your facility, including those who die in the Emergency Department

All patients transferred to another facility for evaluation/treatment not available at your facility

All pediatric patients with injuries between the ages of 0-4 admitted to the facility (even if not for 48hrs or longer)

Open long bone fractures taken to surgery at your facility within 24 hours of arrival at your facility

All patients taken to surgery at your facility for intracranial, intra-thoracic, intra-abdominal, or vascular surgery

Exclusions

These are not eligible;

Late effects of trauma, Injury codes 905-909, ("Late effects" should be documented as such by the physician)

Hip fractures resulting from falls from same height (without other significant injuries)
(Injury codes 820 – 821) Isolated hip fractures/femoral neck fractures when coded with:
(E884.2) - fall from a chair,
(E884.3) - fall from wheelchair,
(E884.4) - fall from bed,
(E884.5) - fall from other furniture,
(E884.6) - fall from commode,
(E885) - fall from same level from slipping, tripping, or stumbling

Unilateral pubic rami fractures resulting from falls from same height (without other significant injuries)

Single-system orthopedic injuries (except femur fractures)

Amputations distal to ankle/wrist NOT admitted to your facility for ≥ 48 hours

Transfers with previous trauma, but now admitted for medical reasons not associated with the trauma or those transferred for personal convenience

Transfers from another facility not meeting inclusion criteria (isolated hip fx/fall from same height, etc.)

Poisoning

Hypothermia and other cold injuries (with no associated trauma) **Unless Trauma Team Activation**

Bites - **insects, snakes (envenomation injuries)**

Chronic subdural hematoma

Anoxic brain injuries due to non-trauma mechanism of asphyxia:

- **Carbon monoxide**
- **Inhalation food/ foreign bodies, other gases, fumes, vapors**